Spanish Peaks
Regional Health Center

23500 U.S. Highway 160 West
Walsenburg, CO 81089
Telephone: 719-738-5204 | 719-738-4586
Fax: 719-738-5760

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Released from: Spanish Peaks Regional Health Center

- ☐ Spanish Peaks Regional Health Center
- ☐ Spanish Peaks Family Clinic/LaVeta
- ☐ Spanish Peaks Women's Clinic
- ☐ Spanish Peaks Specialty Clinic
- ☐ Spanish Peaks Ambulance
- ☐ Other______________________________

Released to:
- ☐ Patient
- ☐ Other Person/ Relationship:______________________________
- ☐ Other Facility

Patient Name ______________________________
Mailing Address ______________________________
City ____________ **State** ________ **Zip** ________
Phone ____________ **Fax** ____________

Other Person / Facility Name ______________________________
Mailing ______________________________
City ____________ **State** ________ **Zip** ________
Phone ____________ **Fax** ____________

Patient's Date of Birth: ______________________________
Email Address: ______________________________

Patient:	☐ Pick Up	☐ Fax	☐ Mail
Other Person:	☐ Pick Up	☐ Fax	☐ Mail
Facility:		☐ Fax	☐ Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: ____

- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Physician Progress Notes
- ☐ Nurses Notes
- ☐ Medication Records
- ☐ Physician Orders
- ☐ Lab/Pathology Results
- ☐ Radiology Report
- ☐ Radiology Images
- ☐ Respiratory
- ☐ Rehab Services
- ☐ Billing Records
- ☐ Non-SPRHC Medical Records
- ☐ Other (specify) ______________________________

I DO ☐ or **I DO NOT** ☐ consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and /or HIV(AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results. *****NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. *****

THE PURPOSE FOR THIS RELEASE:
- ☐ Continuity of Medical Care
- ☐ Damage/Claim Information
- ☐ Personal Use
- ☐ Legal
- ☐ Other: ____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand once this information is disclosed, it may no longer be protected by federal privacy regulations and may be **redisclosed**. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge incomplete forms cannot be processed and there may be a cost to copy these records.

I understand **this consent expires one year from the date of my signature** unless otherwise specified as follows:______________________________. I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to **revoke** this authorization before the date/event of expiration, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original. **Please retain a copy of your records for your personal use.**

~~~~~~**PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED**. ~~~~~~

______________________________ ____________ ______________________________ ____________
Signature of Patient/Representative **Date/Time** **Signature of Witness** **Date/Time**

Name of SPRHC Staff person who released medical records:______________________________**Date:** ____________

OFFICE USE ONLY: Proof of Identification: ______________________________

Number of pages released: ____________ Completion Date: ____________ Delivery method: ____________

Name of staff working on this request: ______________________________ Date request received: ____________

PT. MRN / Account # ______________________________
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